**Provider Training and Patient Education Payor/Provider**
**Round Table Meeting**
*May 4, 2018*
*Salt Lake Community College Miller Campus*
*Professional Development Center*
*Room 213*
*9:00 a.m. – 1:00 p.m.*

MEETING MINUTES

UCOOP Chairs:
Trish Henrie-Barrus, PhD
Melanie Wallentine, MPH

## Welcome and Introductions:

- Trish Henrie-Barrus welcomed everyone to the meeting.
- We are all here today to help stop the opioid crisis in our state.
- Each section will have action items; these will be presented at the 3rd Opioid and Heroin Summit in the Fall.
- Dr. Angela Dunn gave a presentation on State of the Problem.
- Dr. Mark Hiatt reviewed some ground rules and discussed the process of what will be taking place today.
- All documents discussed in this meeting will be available on the UCOOP website. (https://ucoop.utah.gov/healthcare/healthcare-resources/)

## Section 1: General Questions and Discussions:

Action Plan Summaries:

- Please refer to (https://ucoop.utah.gov/healthcare/healthcare-resources/) for Insurer's Action Plans.
- WCF - Paola Stouffer / Charles:
    - There was discussion about the providers not understanding the dosage that the insurers go by, and how through education, this can be fixed.
    - There was discussion about acute and chronic cohorts / maintenance and escalation dose.
- PEHP Dr. Toan Lam / Tom Davies:
    - They developed an Opioid Management Program.
        - They have minimized the impact of opioid prescriptions for the community.

            - A barrier they are facing is that opioids are cheaper and alternative medicine is more expensive.
- Medicaid – Dave Wilde:
    - Because of the increased access to substance abuse care, they have put some guidelines in place.
    - They have a restriction program in place, and are looking to do more with prevention work internally.
    - They are open to the use of SBIRT codes.
        - This is not being utilized very well at this point
- Prime Therapeutics/Regence BCBS - Dustin Howard, Steve Foxley LuGina Mendez-Harper:
    - Prime Therapeutics is a Pharmacy Benefit Management Company that administers the pharmacy benefit of health plans such as BCBS.
        - Concurrent DUR (broad approach):
            - Looks at patient profile for clinical concerns that need to be addressed.
        - Point of Service – Utilization management tools (specific):
            - Programs look at quantities in addition to time to ensure appropriate use.
            - Needs prior authorization.
        - Retrospective program (more specific):
            - Combine pharmacy and clinical information.
            - Outreach to provider for further assessment for patients that are concerning (multiple trips to the ER, different physicians, different pharmacies, etc.).
        - Prospective program:
            - Pharmacists reach out for MAT along with provider.
    - Their reimbursement rates are set and reimbursed to the Pharmacies, not to the Provider.
        - Rates set by a pharmacy network
- Select Health – Dr. Cody Olsen and Dr. Scott Whittle:
    - A barrier they are facing is that there are not enough Medication Assisted Treatment (MAT) providers.
    - They have a developed a dashboard – a place where the provider can look overtime at the MME of a patient.
    - How do we pay for care for those who are at risk?
        - They have payment strategies, and are partnering with Leavitt Partners to develop strategies.

        - Bundle Payments:
            - DRG for detox bundle.
            - Residential to IOP bundle.
                - Local substance abuse authorities.
            - Maintenance phase bundle.
    - They are seeing a problem with providers – they are not sure of what to do once they screen.
        - They see an opportunity by supporting MAT providers.
        - There is opportunity in supporting behavioral health treatment.
        - Provide logistic resources to patients.
            - We need to improve the IT tool for patient referral and distribution strategies.
            - Tech based solutions to coordinate care.
                - SAFE UT is a program in place to help teenagers/youth – we need to make it multi-agency for coordinated care.
    - Screening for opiates is difficult and complicated.
        - Payment should include for screening for all things, not just opioids.
    - Pharmacy side
        - They have a program in place for patients that had seen multiple doctors to obtain medications and limiting them to one prescriber/provider.
            - They have not seen a decrease in MME, but have seen a decrease in ER visits.
            - They are trying to understand population to determine initial cut point for MME.
        - Looking at prescribers who are outliers compared to peers, and educating them.
- United Healthcare/Optum – Dr. Satish Annadata:
    - Objectives are to prevent, treat and support.
    - Prevent:
        - Minimize early exposure by promoting safe alternatives and aligning to CDC guidelines.
        - Reduce inappropriate supply of opioids through real-time medication checks.
        - Track opioid usage and identify high-risk individuals.
    - Treat:
        - Guide personalized treatment plans.
        - Connect people to evidence-based treatment and other services in their communities.

        - Collaborate with care providers as appropriate.
    - Support:
        - Connect individuals to peer support specialists.
        - Equip individuals with recovery tools.
        - Monitor pharmacy claims data.
- Express Scripts – Dr. Lynne Nowalk:
    - Fraud / Waste / Abuse program:
        - Look to see where aberrant behavior is occurring.
        - Monitor distance that a patient is traveling in addition to doctor shopping metrics.
    - Quality networks:
        - Seeing if edits are being acknowledged by the pharmacists.
    - Patient education letter:
        - Every patient that gets a new opioid prescription receives a letter educating them about opioids and safe storage.
    - Analytics:
        - Watching for triggers (patients showing concerning behavior) and contacting physician, etc.

## Section 2: Opioid Addiction Prevention:

- Melissa Cheng gave a history about the opioid addiction prevention efforts in the state.
- SBIRT = Screening, Brief, Intervention, Referral to, Treatment.
    - This is a free training provided by the U of U.
        - www.sbirt@hsc.utah.edu
- The biggest struggle for providers in S.B.I.R.T. – is the Referral and Treatment.
    - Where can these patients get referred?
    - Are there enough providers out there to provide treatment?
- Availability of mental health and substance abuse professional is a huge barrier, difficult for providers to screen and interview when they don't have a place to refer.
    - What is needed is SBIRT coordinated care.
- Discussion around insurer panels and how to get the right people on those panels.
    - For every 3 primary care models there is a behavioral health practitioner on the panels.
- A barrier for patients is the co-pays for each mental health and physical therapy visit, even though the outcome could be very beneficial.

## Action Items for Section 2:

- Get behavioral health more involved (pain therapy)

- Not separating mental health/physical health
- Benefit design and payment strategy
- Educate behavioral therapists on pain/psych/addiction med.
- Referral directory
- Definition of quality of mental health provider
- Press awareness of collaboration (payers + providers)
- Exercise component (more than referral to physical therapy)
- Better models (i.e. CBT + exercise)

**Provider Recommendations:** Provide incentives that encourage practitioners to assess for Mental Health issues prior to prescribing opioids. Reimburse for SBIRT codes.

## Section 3: Pain Management (Acute and Chronic):

- Dr. Michael Giovanniello gave an overview about pain management in our State.
    - Chronic pain is not going away.
        - Patients want pain to go away, but they just need to learn how to manage their pain.
        - Treat acute pain well up front to prevent chronic pain from developing.
        - We need to look into non-pharmaceutical ways to help manage pain (chiropractic care, physical therapy, massage therapy, acupuncture, etc.)
        - The brain cannot tell the difference between pain and addiction.
    - Which groups of patients are we working with?
        - Patients that have been on opioids for a longer period of time vs. those who are just beginning.
        - We can stop the opidemic now by not prescribing more opioids than necessary.
    - Discussion around compounded medication not being covered.
        - The issue they have is that pharmacies were overcharging for compounded medications.
        - This is why insurers stopped covering it.
            - The medication is the same price; the pharmacies were robbing the insurers.
        - This is an item worth revisiting by insurers.
    - Advocate for partial fills.
        - When a patient may only need 6 pills, but prescribed12.
            - They will have to pay second co-pay.
            - Partial fills will benefit the patient for co-pays, for fewer pills, less amount.

- Patients may not want pain pills after surgery.
  - They should be asked if they would like them.
- We need to use the studies that are out there to educate the public that they do not need opioids.
  - Make sure that all of the decisions that are made are data driven.
- Bring in patients to listen to what is being said, and to share their experience (those that are recovering and currently struggling).
- Look into forming sub-groups to work on these action items.

## Action Items:

- Incentivize patient education
- Fall summit- have payers describe alternative treatments/coverage
- Ratings/evaluations
- AMA Doc on prior authority and joint statement
- Public awareness of what to expect from a Doctor appointment for pain
- Separate Acute, Chronic, and Complex
- How to bring payor communities together
- Patient's needs to be treated with conservative care before they even consider opioids.
  - Follow guidelines
- Treat acute pain well
- Consider acute or chronic pain
  - Good perioperative care – payment structure/adjustments too (ask patients if they need/want opioids – stop practice of assuming all post-op patients need opioids
- Self-efficacy to increase movement/exercise
- Include dentistry, physical therapist, podiatry, ER/ED, patients (chronic, acute, recovery, involved) to this group.
- RFP for imorative payer plan for what we are discussing
  - E.g. CMS innovation???
- Payer policies (narcotics for NSVD, C/S, engage OB's in this more)
- IMC data on post-symptoms prescriptions of opioids – share consumption/behavior across state for clinicians and payers
- Support efforts to safely dispose of Rx (educate, national efforts)
- Compound medications coverage by payers (need evidence and cost studies)
- Explore MT
- This group (way to share data real time – e.g. APCD, death, etc.)
- Advocate partial fills (need to get rid of multiple co-pays)
- Increase public awareness/change culture around pain/opioids

- How to get access to CSD data
- Measurement of function for patients
- Next meeting talk about: cost to payer and patients, law suit participation, state legislative issues

  **Provider Recommendation:** Limited or decreased co-pay for multiple visit treatment plans such as with Chiropractic, PT, or Psychological therapies.

  **Provider Recommendation**: Eliminate pre-authorizations for treatments that are recommended in approved guidelines (CDC, or others)

**Provider Recommendations:**

- Provide incentives for providers to utilize current guidelines for pain management.
- Add more providers to your behavioral health network.
- Encourage certification in pain management put out by UMA, UCPA, Insurance Companies. That gives insurers a way to create preferred provider incentives, also sets a standard by which providers can be measured. Builds public awareness and unites groups across the state in a proactive action.
- These barriers to effective opiate-sparing tools deter patients from receiving alternative treatments and promote the easier route of prescribing opioids.

**Other Provider Recommendations:**

- Insurance brackets which offer chronic pain coverage that allow for discounted access to certain treatments at a higher premium.
- Recent findings published in the Lancet indicate:
  - We are not following the research, we need to actually implement best practices and guidelines
  - We need to redesign some clinical pathways to allow clinicians to follow the evidence
  - Integrated health care needs to become the norm
  - To allow this to happen changes to payment systems and legislation need to happen
  - Public health and prevention strategies of exercise and education need to be implemented

## Section 4: Substance Use Disorder Treatment:

- We did not have time to discuss this section.
- It will be a session at the upcoming 3rd Opioid and Heroin Summit in the Fall.